

Third Annual Report on Graduate Medical Education in Connecticut

INTRODUCTION

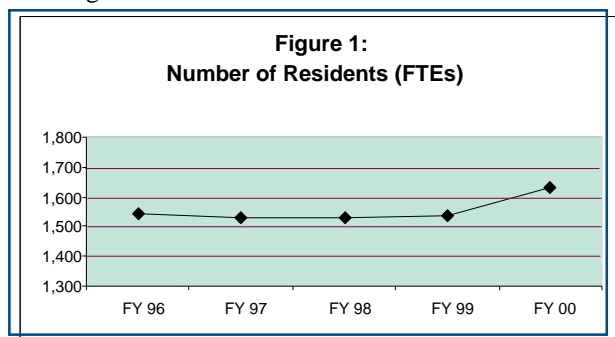
Public Act No. 99-172 mandated the Office of Health Care Access (OHCA) to develop an annual study on graduate medical education (GME) and its impact on Connecticut hospitals. This legislation cited three specific areas to be addressed: the financial impact of GME; its effect on the sufficiency of the health care provider workforce; and its effect on access to health services. It also called for a council to be established to advise the Commissioner on the report.

This publication is the OHCA's third annual report on graduate medical education (GME) and its impact on Connecticut hospitals. Unless otherwise noted, all data cited in this report are from the Office of Health Care Access Hospital Budget System. These filings are reported by the hospitals and reviewed and verified by OHCA.

GRADUATE MEDICAL EDUCATION PROGRAMS IN CONNECTICUT

There were 1,632 resident and intern full time equivalent (FTE) positions in Connecticut hospitals during fiscal year 2000 (excluding Connecticut Children's Medical Center).

Figure 1 shows the number of resident and intern FTEs from 1996 through 2000.



Overall, there has been a 5.6% net increase in the number of FTE positions during the five-year period. However, while each hospital can increase the number of residents it employs, it will not receive GME payments for residents in excess of 1996 levels; the number of FTE residents eligible for

federal funding was capped at 1996 levels under the BBA of 1997.

HOW GME IS FINANCED

The federal government is the primary payer of the costs associated with GME through the Medicare program; states voluntarily support graduate medical education through their Medicaid programs. Unlike Medicare, state Medicaid programs have no statutory obligation to support GME. Most states make GME payments under their fee-for-service program. In Connecticut, Medicaid provides direct graduate medical education (DGME) payments only, using the same formula used by Medicare.

Remaining GME costs are financed by a variety of sources, including the Department of Veterans' Affairs, the Department of Defense, state and local government appropriations, faculty practice plans and philanthropies, and other public and private third-party payers' payments for patient care services.

This report focuses on the financing by Medicare and Medicaid, as the majority of GME payments are made to Connecticut hospitals by these programs, and because there is no way to specifically track the contribution from third party payers.

CURRENT FACTORS INFLUENCING GME PAYMENTS

Two relatively recent trends in health care have significant implications for how GME programs are operated and financed.

First, teaching hospitals tend to have higher costs that place them at a competitive disadvantage with community hospitals when competing for managed care contracts. In the past, private payers have subsidized the educational missions of teaching hospitals through higher payments. However, the growth of managed care with its capitated financial arrangements, coupled with increased competition within health care markets, has eroded private payer subsidies for teaching.

In addition, recent changes in Medicare and Medicaid funding for GME have added to the fiscal constraints on teaching institutions.

Second, Medicaid managed care growth has reduced Medicaid revenues and payments for serving a disproportionate share of low-income patients that teaching hospitals serve. This reduction in Medicaid revenues has been accompanied by an increase in uncompensated care losses. And while the Balanced Budget Refinement Act of 1999 (BBRA) restored some of the Medicare cuts introduced by prior legislation, the amount is relatively modest when compared to total BBA cuts. The uncertainties and financial pressures inherent in today's dynamic health care environment have suggested the possibility of needed changes in the way GME is financed.

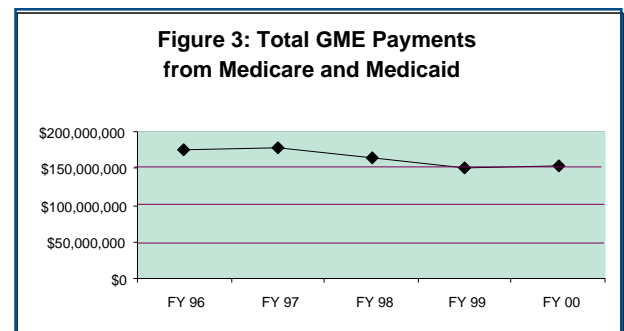
GME DOLLARS TO HOSPITALS — FINANCIAL IMPLICATIONS OF GME FUNDING ON HOSPITALS

Seventeen Connecticut hospitals received GME payments as a part of their gross revenue in 2000, up from 16 hospitals in the prior year. In the past, Connecticut Children's Medical Center pediatric services residents did not receive GME payments because funding was based on the number of Medicare discharges. Congress created the Children's Hospitals Graduate Medical Education program in 1999 as part of the Healthcare Research and Quality Act, to provide independent teaching hospitals with support similar to that provided to other teaching hospitals. The first payments were made in FY 2000, and the Connecticut Children's Medical Center received \$504,876 under this program.

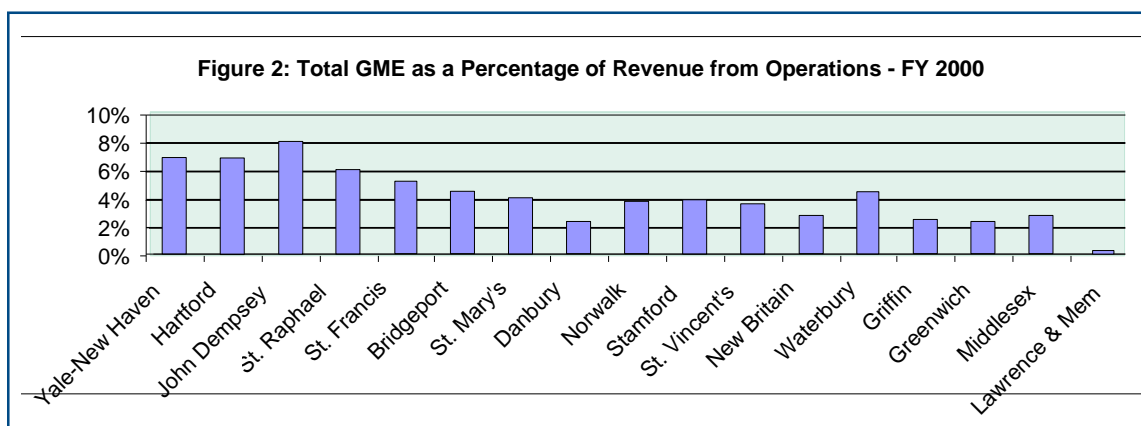
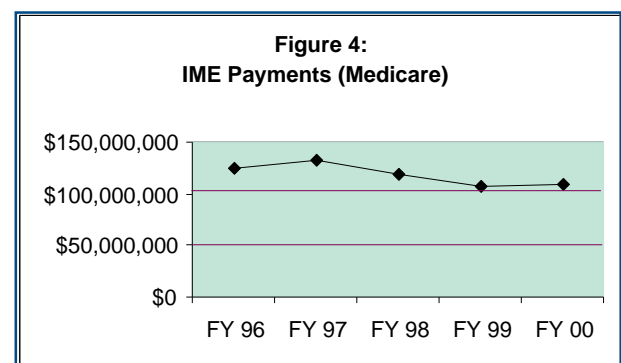
For most hospitals in Connecticut, GME contributes six percent or less of their total revenue from operations, the amount of money received from patient care services (**Figure 2**).

Overall, GME as a percentage of total revenue (which includes revenue from direct patient services and indirect revenue from such sources as parking lots, cafeterias, philanthropies, etc.) rose from of 3.8% in 1997 to 4.7% in 2000.

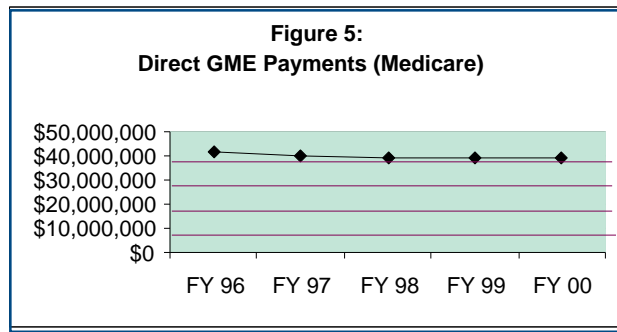
In fiscal year 2000, approximately \$154 million in GME payments was received from Medicare and Medicaid. This amount is approximately 14% lower than 1997, the year with the highest level of GME payments between 1994 and 2000 (**Figure 3**).



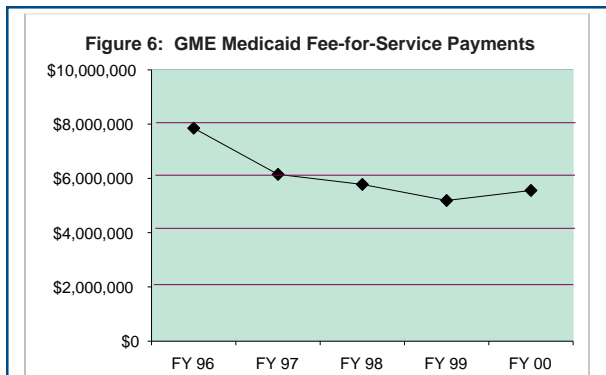
The majority of this decline is largely due to reductions in Indirect GME (IME) payments (**Figure 4**), down 14% since a high in 1997.



The amount of direct GME payments has declined every year in the past five years (**Figure 5**).



Medicaid GME payments have increased 7.4% since last year¹, but have decreased approximately 29% in the past five years (**Figure 6**).



Source: State of Connecticut Department of Social Services

Finally, the true cost of graduate medical education is a question that is frequently raised, but difficult to answer. Understanding the actual costs of GME as compared to the payments is an area in which many in the hospital community have strong feelings.

Non-teaching hospitals believe they have additional costs that teaching hospitals do not, such as offering services 24 hours a day with staff paid at full market value, rather than with residents paid at a lower rate.

Teaching hospitals are concerned that the current payment structure, in particular the reduction of payments from Medicare, puts them at an increasing financial disadvantage. Data reported to OHCA on teaching hospitals' intern and residents' salary, fringes and other program costs in 2000 totaled \$159,624,570, at an average of \$97,809 per FTE.

In summary, despite these concerns, the amount of a teaching hospital's revenue that comes from GME

payments is a small part of its overall gross revenues, and is likely to continue to decline over the next several years.

WORKFORCE ISSUES

While establishing the effect of the financial structure of GME payments on hospitals is relatively straightforward; assessing the influence of graduate medical education on the sufficiency of the health care provider workforce is not.

Although Connecticut has a high number of physicians per capita (3.97 physicians per 1,000 residents²) as compared to other states, it is unlikely that the number of residents contributes in a practical way to the sufficiency of the work force. There is little evidence to assess whether the number of residents in GME programs has a significant impact on whether Connecticut has too few or too many physicians. The effect of GME on the workforce may be less relevant in establishing an appropriate minimum number of physicians in the state, and more important in developing and maintaining diverse clinical skills available to state residents.

Another workforce effect of a GME program is its ability to attract highly qualified people and clinical programs. Although it is difficult to quantify this effect, advisory council members and other hospital representatives attribute to their teaching programs the ability to attract clinicians in difficult to fill, specialty clinical fields. Apparently the challenges of a teaching environment appeal to many practitioners, particularly in sub-specialty areas.

It should be noted that the number of residency positions that a hospital offers in a given residency program is determined through direct oversight by an accrediting process as well as by the indirect process of market forces.

The Accreditation Council for Graduate Medical Education (ACGME) determines the number of positions that a hospital may have in a specific residency program. The ACGME establishes national standards for GME, including minimum number of hours of education and clinical service that are required within each specialty. It then assesses and approves programs based on these standards. Through this accreditation process, a hospital must document that a residency program has the capacity to provide the necessary education and volume of clinical

experience to each of the program's residents, or the ACGME will reduce the number of resident positions allocated to that program.

EFFECT ON ACCESS TO HEALTH CARE

The relationship between GME and access to health care is, like the issue of workforce sufficiency, unclear. Treatment is provided at all Connecticut hospitals regardless of patients' ability to pay. However, it is likely that without GME programs in our hospitals, this provision of health care to the uninsured and underinsured would be more costly to taxpayers. Without the significant contribution of Medicare payments (both direct and indirect), Connecticut citizens might be faced with higher health care costs to continue the current standard of hospital treatment to all. Thus, GME programs do not directly alter the level of access to inpatient care in Connecticut as much as they affect how this access to care is financed.

That said, it is important to consider the amount of inpatient and outpatient service provided through GME programs, regardless of the insurance status of the patient. The ACGME has established regulations on the minimum and maximum hours of education and patient care activities that residents must have in each year of their graduate education. Residents provide a significant amount of patient services while enrolled in GME programs. In addition to patient services provided in inpatient settings, each resident is required to work 20 hours each week in an outpatient setting. This amounts to approximately 3,000 hours per resident over the course of his or her graduate medical education. In addition, residents expand access to care in urban areas, providing access to those who would otherwise not have an opportunity to receive hospital services. In turn, this may lower the cost of those services to Connecticut taxpayers.

CONCLUSION

Seventeen Connecticut hospitals received approximately \$154 million graduate medical education dollars from Medicare and Medicaid in 2000. In FY 2000, Medicare direct and indirect GME payments totaled \$39 and \$109 million, respectively, with Medicaid contributing an additional \$5.6

million. The amount of the state's teaching hospitals' revenue derived from GME payments is relatively small, it has declined over the past several years and is expected to continue to decline in the future due to federal payment policy changes.

Although GME programs may have little effect on the sufficiency of the physician workforce in Connecticut in terms of the actual number of physicians, their effect may be more appropriately viewed as one of establishing and maintaining diverse clinical skills available to the state's citizens.

The state's two medical schools, the University of Connecticut and Yale University, supply the majority of residency positions in Connecticut's hospitals and other health care settings. It is likely that without GME programs in our teaching hospitals, the cost of providing the uninsured and underinsured with access to care would be more burdensome to Connecticut taxpayers.

Connecticut's health care delivery system, like the rest of the nation, is in a period of flux largely driven by the changing nature of health care financing. Both public and private payers have attempted to control the ever-increasing costs of providing care. Consequently, payments for graduate medical education have declined and this trend is expected to continue. The Office of Health Care Access will continue to monitor changes in public policy involving GME, in an effort to provide policy makers with the information necessary to appropriately address the issue of decreasing revenue supporting graduate medical education.

NOTES

¹ There was a higher ratio of Medicaid days to total days in FY 2000 as compared to FY 1999 for certain hospitals, which could account for the overall increase in payments.

² Kaiser Family Foundation, State Health Facts Online - <http://statehealthfacts.kff.org>